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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 17-0008

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Division of Medicaid & Children's Health Operations

October 24, 2017

Russell S. Barron, Director
Department of Health and Welfare
Towers Building - Tenth Floor
PO Box 83720
Boise, ID 83720-0036

RE: Idaho State Plan Amendment (SPA) Transmittal Number 17-0008

Dear Mr. Barron:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the enclosed State Plan Amendment (SPA), Transmittal Number 17-0008. This SPA amends Idaho's Basic Alternative Benefit Plan (Basic ABP) to align the Basic ABP's benefit plans with the changes that have been made to the Base Benchmark plan.

This SPA was approved by CMS on October 11, 2017, with an effective date of January 1, 2017. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Idaho State Plan.

If there are any questions concerning this approval, please contact me or your staff may contact Walter Neal at walter.neal@cms.hhs.gov or at (206) 615-2330.

Sincerely,

Digitally signed by David L.

[redacted]

David L. Meacham
Associate Regional Administrator

Enclosure

cc:
Matt Wimmer, IDHW
Lisa Hettinger, IDHW

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Idaho**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

ID-17-0008

Proposed Effective Date

01/01/2017 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year		$
Second Year		$

Subject of Amendment

Changes made to Basic ABP to align with changes made to Base Benchmark plan.

Governor's Office Review

- ◉ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ○ **Other, as specified**

  Describe:

Signature of State Agency Official

Submitted By:	**Dea Kellom**
Last Revision Date:	**Sep 14, 2017**
Submit Date:	**Mar 28, 2017**

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- B

Alternative Benefit Plan Populations ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Basic Alternative Benefit Plan

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Parents and Other Caretaker Relatives	Voluntary	X
+	Pregnant Women	Voluntary	X
+	Infants and Children under Age 19	Voluntary	X
+	Former Foster Care Children	Voluntary	X
+	Extended Medicaid due to Spousal Support Collections	Voluntary	X
+	Transitional Medical Assistance	Voluntary	X
+	Deemed Newborns	Voluntary	X
+	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Voluntary	X
+	Aged, Blind and Disabled Individuals in 209(b) States	Voluntary	X
+	SSI Beneficiaries	Voluntary	X
+	Individuals Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Voluntary	X
+	Certain Individuals Needing Treatment for Breast or Cervical Cancer	Voluntary	X

Enrollment is available for all individuals in these eligibility group(s). No

Targeting Criteria (select all that apply):

☒ Income Standard.

Income Standard:

◉ Income standard is used to target households with income at or below the standard.

○ Income standard is used to target households with income above the standard.

The income standard is as follows:

Alternative Benefit Plan

○ A percentage:

◉ A specific amount

The standard is as follows:

◉ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Other basis for income standard

Statewide standard

	Household Size	Income Standard	
+	1	282	X
+	2	355	X
+	3	448	X
+	4	540	X
+	5	633	X
+	6	725	X
+	7	819	X
+	8	911	X
+	9	986	X
+	10	1,061	X

Additional incremental amount?

◉ Yes ○ No

Increment amount $ 75

☐ Disease/Condition/Diagnosis/Disorder.

☒ Other.

Other Targeting Criteria (Describe):

Individuals with healthcare needs that cannot be met with the Standard State Plan
Pregnant individuals within the income limits above are eligible for full Medicaid
Pregnant individuals with incomes greater than those listed above, but below 133% FPL are eligible for pregnancy-related services
Children 0 - 6 in families with income under 142% FPL are eligible for Medicaid
Children 6 - 18 in families with income under 133% FPL are eligible for Medicaid
Deemed Newborns - Automatic Eligibility
Former Foster Care Children under 26 years old, who were in Foster Care at age 18 - Automatic Eligibility
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care - Automatic Eligibility

Alternative Benefit Plan

Extended Medicaid due to Spousal Support Collections - Continue with previous eligibility

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130724

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- B

Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2b

These assurances must be made by the state/territory if the ABP Population includes any eligibility groups other than or in addition to the Adult eligibility group.

When offering voluntary enrollment in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent), prior to enrollment:

☑ The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.

☑ The state/territory assures it will effectively inform individuals who voluntary enroll of the following:

a) Enrollment is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan at any time and regain immediate access to full standard state/territory plan coverage;

c) What the process is for disenrolling.

☑ The state/territory assures it will inform the individual of:

a) The benefits available under the Alternative Benefit Plan; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan differs from the approved Medicaid state/territory plan.

How will the state/territory inform individuals about voluntary enrollment? (Check all that apply.)

☐ Letter

☐ Email

☒ Other:

Describe:

The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that includes informing each eligible individual of the available benefit options. The Department will inform each individual in a covered population that enrollment in the Basic Alternative Benefit Plan is voluntary (i.e., participants may opt in), and that such individuals may opt out of the Basic Alternative Benefit Plan at any time and regain immediate eligibility for Medicaid benefits under the State plan.

The Department will provide such information, in writing, to covered populations, at the following opportunities:
• Initial application for assistance;
• Notice of eligibility determination; and
• Selection of primary care case manager.

As part of the application process, the applicant will fill out a "Rights and Responsibility" page that includes areas for them to confirm that they have chosen their plan.
http://healthandwelfare.idaho.gov/Portals/0/FoodCashAssistance/ApplicationForAssistance.pdf

The Participant handbook, "Idaho Health Plan Coverage," tells the participant how they can enroll in another plan. There is also a document entitled Medicaid Comparison Benefits. Both documents are available on line at http://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx, and are also available in hard copy upon request from any Health and Welfare office.

Alternative Benefit Plan

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about voluntary enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

The state informs participants of their benefit plan options at the time of enrollment, at redetermination, and upon request.

Please describe the state/territory's process for allowing voluntarily enrolled individuals to disenroll.

The Department has an "Any Door" policy. Participants can notify their local eligibility office, their regional office, their Healthy Connections provider, or the Medicaid Central Office and obtain information about changing plans.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.

Where will the information be documented? (Check all that apply.)

☒ In the eligibility system.

☐ In the hard copy of the case record.

☐ Other:

What documentation will be maintained in the eligibility file? (Check all that apply.)

☒ Copy of correspondence sent to the individual.

☒ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other:

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in an Alternative Benefit Plan and the total number who have disenrolled.

Other Information Related to Enrollment Assurance for Voluntary Participants (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- B

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3

Select one of the following:

- (•) The state/territory is amending one existing benefit package for the population defined in Section 1.
- ( ) The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Basic Alternative Benefit Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- (•) Benchmark Benefit Package.
- ( ) Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ( ) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ( ) State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ( ) A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- (•) Secretary-Approved Coverage.
  - ( ) The state/territory offers benefits based on the approved state plan.
  - (•) The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

Idaho offers benefits that are based on Idaho's Base Benchmark Small Group plan, Preferred Blue, plus additional services that are appropriate for the Medicaid participants choosing this plan.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. Yes

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

1. The state assures that all services in the base benchmark have been accounted for through the benefit chart found in ABP5.
2. The state assures the accuracy of all information in ABP5 depicting amount, duration, and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130801

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- B

Alternative Benefit Plan Cost-Sharing	ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.	No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

State Name: Idaho

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ____ - __ - ____

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Preferred Blue, Blue Cross of Idaho Health Services, Inc.

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved.

Alternative Benefit Plan

■ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Primary Care Visit to Treat an Injury or Illness
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Specialist Visit
Source: Base Benchmark Small Group
Remove
Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Selected services require prior authorization.

Benefit Provided: Other Practitioner Office Visit
Source: Base Benchmark Small Group
Remove
Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Selected services require prior authorization.

Remove

Benefit Provided: Outpatient Facility Fee (e.g., ASC)

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Ambulatory Surgery Center (ASC).

Selected services require prior authorization.

Remove

Benefit Provided: Outpatient Surgery Physician/Surgical Services

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Selected services require prior authorization.

Remove

Benefit Provided: Urgent Care Centers or Facilities

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Chiropractic Care

Source: Base Benchmark Small Group

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: Six (6) visits

Duration Limit: None

Scope Limit:

Coverage only for treatment involving manipulation of the spine to correct a subluxation condition.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The Department will review for medical necessity and prior authorize chiropractic services after the initial six visits per year.

Benefit Provided: Radiation Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Renal Dialysis

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Respiratory Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Enterostomal Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Home IV Therapy

Source: Base Benchmark Small Group

Remove

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Hospice

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Concurrent care for children under the age of 21 is covered.

As soon as they begin to receive this benefit, participants are transitioned to the Enhanced ABP, so extended coverage of hospice care is not provided under this Basic ABP.

Add

Alternative Benefit Plan

■ 2. Essential Health Benefit: Emergency services Collapse All ☐

Benefit Provided: Emergency Room Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency Transportation/Ambulance

Source: Base Benchmark Small Group

Remove

Authorization: Retroactive Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided: Inpatient Hospital Services (e.g., Hospital Stay)
Source: Base Benchmark Small Group
Remove
Authorization: Authorization required in excess of limitation
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Inpatient stays are reviewed by the Department or its contractor after three days, or in four days if the participant has had a cesarean section.

Selected services require prior authorization.

Benefit Provided: Inpatient Physician and Surgical Services
Source: Base Benchmark Small Group
Remove
Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Selected services require prior authorization.

Benefit Provided: Radiation Therapy: Inpatient
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 4. Essential Health Benefit: Maternity and newborn care Collapse All ☐

Benefit Provided: Prenatal and Postnatal Care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

See "Other 1937 Benefits" for additional provider types covered beyond the Base Benchmark: Other Licensed Practitioner, Licensed Midwife.

Participants in the optional pregnant individuals group may receive EHB and other 1937 services that are pregnancy-related as described below:
Idaho covers services that are necessary for the health of the pregnant individual and fetus, or that have become necessary because of the individual having been pregnant and services for other conditions that might complicate the pregnancy. Coverage includes prenatal care, delivery, postpartum care, and family planning services. This coverage includes services for the mother or fetus for other conditions that might complicate the pregnancy, including those for diagnoses, illnesses, or medical conditions that might threaten the carrying of the fetus to full term or the safe delivery of the fetus. Pregnancy-related services are covered for a postpartum period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

Idaho does not cover services for pregnant individuals that are medically contraindicated during pregnancy or elective procedures for conditions that do not threaten the health of the pregnant individual, the carrying of the fetus to full term, or the safe delivery of the fetus.

Based on the benefits provided, this group does not meet Minimum Essential Coverage under section 5000A(f)(1)(E) of the Internal Revenue Code on 1986.

Benefit Provided: Delivery and All Inpatient Services-Maternity Care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Freestanding Birth Centers are not a recognized provider type in Idaho and are not approved for Idaho Medicaid payment. Freestanding Birth Centers are not licensed in Idaho.

Add

Alternative Benefit Plan

Collapse All ☐

☑ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Remove

Benefit Provided: Substance Use Disorder Outpatient Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Qualified Providers:
1) Licensed physician
2) Advanced Practice Registered Nurse
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Marriage and Family Therapist
7) Providers who hold at least a Bachelor's degree, a Certification or Licensing in their field, and meet requirements of Idaho Department of Health and Welfare or its Contractor
8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
9) Registered Nurse

Remove

Benefit Provided: MH/BH Inpatient Services

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Mental Health/Behavioral Health Inpatient Services.

Services are not provided in an IMD.

Remove

Benefit Provided: Substance Use Disorder Inpatient Services

Source: Secretary-Approved Other

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The Department covers Substance Use Disorder Inpatient Services with services that are the same as the Base Benchmark with the exception of Residential Treatment services.

Services are not provided in an IMD.

Benefit Provided:
Community-Based Rehabilitation Services

Source:
Secretary-Approved Other

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Program Description: Community-based rehabilitation services (CBRS); 1905(a)(13)(C) of the Act.

* CBRS services consist of evidence-based practices that are restorative interventions or interventions that reduce disability and that are provided to participants with serious, disabling mental illness, emotional disturbance or substance use disorders for the purpose of increasing community tenure, elevating psychosocial functioning, minimizing psychiatric symptomatology or eliminating or reducing alcohol and drug use and implementing structure and support to achieve and sustain recovery, and ensuring a satisfactory quality of life. Services include treatment planning, and the provision and coordination of treatments and services delivered by multidisciplinary teams under the supervision of a licensed behavioral health professional staff, physician or nurse, or an endorsed/certified school psychologist.

* Interventions for psychiatric symptomatology will use an active, assertive outreach approach, including use of a comprehensive assessment and the development of a community support treatment plan, ongoing monitoring and support, medication management, skill restoration, crisis resolution and accessing needed community resources and supports.

* Interventions for substance use disorders will include substance use disorder treatment planning, psychoeducation and supportive counseling, which are provided to achieve rehabilitation and sustain recovery and restoration of skills needed to access needed community resources and supports. These services are provided in conjunction with any professional or therapeutic behavioral health services identified as necessary for the member.

Services may be provided by one of the following contracted professionals within the scope of their practice:
1) Licensed physician
2) Advanced Practice Registered Nurse
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Marriage and Family Therapist
7) Providers who hold at least a Bachelor's degree, are licensed or certified in their field (i.e., Adult or Children's Certificate in Psychosocial Rehabilitation), and who meet requirements of the Idaho Department of Health and Welfare or its Contractor
8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
9) Registered Nurse

Remove

Benefit Provided:
Partial Care

Source:
Secretary-Approved Other

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Program Description: Partial Care Treatment; 1905(a)(6) of the Act.

* Services are prior authorized, and there is no limitation in amount, duration or scope.

* A distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care that is reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or reduce disability or restore the individual's condition and functional level and to prevent relapse or hospitalization. These services occur through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition.

* Partial Care is a program of services that include support therapy, medication monitoring, and skills building as appropriate for the individual. Each service must be delivered by a person licensed or certified to deliver those services.

Partial Care treatment may be provided by one of the following contracted licensed or certified professionals within the scope of their practice:
1) Licensed physician
2) Advanced Practice Registered Nurse
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Marriage and Family Therapist

7) Providers who hold at least a Bachelor's degree and are Licensed Social Workers
8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
9) Registered Nurse

- These licensed practitioners provide supervision to unlicensed practitioners, including certified alcohol and drug counselors.
- Such supervision is included in the State's Scope of Practice Act for the supervising licensed practitioner.
- The licensed practitioner assumes professional responsibility for the services provided by the unlicensed practitioner.

Remove

Benefit Provided: MH/BH Outpatient Services: Group Therapy

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: MH/BH Outpatient: Family and Individual Therapy

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: MH/BH Outpatient Services: ECT Therapy

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
MH/BH Outpatient Services: Med Management

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

■ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The Department covers at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class.

Prior Authorization criteria are developed by the Department's clinical pharmacists with input from the Medical Director, the Pharmacy and Therapeutics Committee, and the Drug Utilization Review Board. The criteria used to place drugs on prior authorization are based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug, and quality evidence provided by established drug compendia, and the Drug Effectiveness Review Program.

See "Other 1937 Benefits" for services provided in excess of the Base Benchmark.

Alternative Benefit Plan

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices Collapse All ☐

Benefit Provided: Home Health Care Services: Skilled Nursing

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Skilled Nursing services provided through a Home Health Agency.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Rehabilitation Services: PT, OT, SLP

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: Twenty (20) visits/yr. (rehabilitative services)

Duration Limit: None

Scope Limit: PT, OT, SLP rehabilitation services are for the purpose of restoring certain functional losses due to disease, illness, or injury.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The Base Benchmark limit is up to 20 visits for all occupational therapy (OT), speech-language pathology services (SLP), and physical therapy (PT) combined, and includes both rehabilitation and habilitation. To comply with 45 CFR 156.115(a)(5)(iii), Idaho Medicaid is establishing separate, equal 20-visit limits each for rehabilitation and habilitation. Services are not provided through a Home Health Agency.

See Outpatient Rehabilitation services in excess of the Base Benchmark in "Other 1937 Benefits."

Benefit Provided: Habilitation Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: Twenty (20) visits/yr. (habilitative services)

Duration Limit: None

Scope Limit:

PT, OT, SLP habilitation services related to developing skills and functional abilities necessary for daily living and skills related to communication of persons who have never acquired them.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The Base Benchmark limit is up to 20 visits for all occupational therapy (OT), speech-language pathology services (SLP), and physical therapy (PT) combined, and includes both rehabilitation and habilitation. To comply with 45 CFR 156.115(a)(5)(iii), Idaho Medicaid is establishing separate, equal 20-visit limits each for rehabilitation and habilitation. Services are not provided through a Home Health Agency.

See Habilitation Services in excess of the Base Benchmark in "Other 1937 Benefits."

Remove

Benefit Provided: Durable Medical Equipment

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Items that are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of injury, disease, or illness, and are appropriate for use in any setting in which normal life activities take place.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

See DME in "Other 1937 Benefits" for services in excess of the Base Benchmark.

Remove

Benefit Provided: Skilled Nursing Facility

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: 30 days per year

Duration Limit: None

Scope Limit:

Skilled Nursing Facility services for rehabilitation.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

As soon as they begin to receive this benefit, participants are transitioned to the Enhanced ABP, so extended coverage of SNF care is not provided under this Basic ABP.

See Skilled Nursing Facility in "Other 1937 Benefits" for services in excess of the Base Benchmark.

Alternative Benefit Plan

Add

Alternative Benefit Plan

■ 8. Essential Health Benefit: Laboratory services Collapse All ☐

Benefit Provided: Diagnostic Test (X-ray and Lab Work)

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Imaging (CT/PET Scans, MRIs, Nuclear Cardiology)

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Remove

Benefit Provided: Preventive Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The Department will provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Remove

Benefit Provided: Preventive Care/Screening/Immunization

Source: Secretary-Approved Other

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The Basic Alternative Benefit Plan includes the following:
- Health Risk Assessment, which consists of:
• An initial health questionnaire; and
• A well child screen; or
• An adult physical.

- The health questionnaire is designed to assess the general health status and health behaviors of a recipient. This information will be used to provide customized health education. The health questionnaire will be administered at initial program entry and periodic intervals thereafter.
- A well child screen or adult physical conducted at periodic or interperiodic intervals which constitutes a health risk assessment will consist of a comprehensive physical examination and health education.

Alternative Benefit Plan

The Well Child Screen includes periodic medical screens and services completed at intervals recommended by the U.S. Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

The Basic Alternative Benefit Plan for both children and adults includes an annual preventive health visit and services with "A" and "B" recommendations by the U.S. Preventive Services Task Force.

Remove

Benefit Provided: Diabetes Education

Source: Base Benchmark Small Group

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: 24 hrs group sessions + 12 hrs individual per 5 yr

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. More can be authorized when medically necessary.

Remove

Benefit Provided: Tobacco Cessation Counseling

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered in accordance with USPSTF recommendations.

Remove

Benefit Provided: Dietary Counseling

Source: Secretary-Approved Other

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:

Two (2) visits per year

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 10. Essential Health Benefit: Pediatric services including oral and vision care Collapse All ☐

Remove

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Routine Eye Exam for children through the month of their twenty-first (21st) birthday.

Selected services require prior authorization.

Remove

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Orthodontia: Children through the month of their twenty-first (21st) birthday.

Remove

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Eyeglasses for children through the month of their twenty-first (21st) birthday.

Participants who have been diagnosed with a visual defect and who need eyeglasses for correction of a refractive error can receive one (1) pair of single vision or bifocal eyeglasses annually. Frames or lenses may be provided more frequently when medically necessary.

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Dental check-up for children through the month of their twenty-first (21st) birthday.

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Basic Dental Care - Children through the month of their twenty-first (21st) birthday.

Selected services require prior authorization.

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Major Dental Care – Children through the month of their twenty-first (21st) birthday.

Selected services require prior authorization.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Residential Treatment

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The Department substitutes Community-Based Rehabilitation Services and Partial Care for Residential Treatment (part of the EHB 5 Mental/Behavioral Health Outpatient services and also Substance Use Disorder Inpatient services): There are no Psychiatric Residential Treatment Facilities licensed or certified in the State of Idaho.

This is an IMD.

Base Benchmark Benefit that was Substituted: Partial Hospitalization

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The Department substitutes Community-Based Rehabilitation Services and Partial Care for Partial Hospitalization (part of the EHB 5 Mental/Behavioral Health Outpatient services).

This is an IMD.

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Non-Emergency Care When Traveling outside the U.S.

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit: Not covered, in accordance with federal statute.

Add

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Remove

Other 1937 Benefit Provided:
Licensed Midwife

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Services include antepartum, intrapartum, up to six (6) weeks of postpartum maternity care, and up to six weeks of newborn care.

Other:
Program Description: Medical Care furnished by licensed practitioners; 1905(a)(6) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Licensed Midwife (LM).

LM services include maternal and newborn care provided by LM providers within the scope of their practice and who are licensed by the Idaho Board of Midwifery.

Remove

Other 1937 Benefit Provided:
Optometrist and Ophthalmologist Services: Adults

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
One pair glasses or contacts post cataract surgery

Duration Limit:
None

Scope Limit:
None

Other:
Program Description:
* Physician Services; 1905(a)(5)(A) of the Act; and
* Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law; 1905(a)(6) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Optometrist and Ophthalmologist Services for adults.

The Department will cover services to monitor conditions that may cause damage to the eye and acute conditions that without treatment may cause permanent damage to the eye. One pair of glasses or contacts is covered post cataract surgery.

Other 1937 Benefit Provided:
Dental Services: Adults

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Program Description: Dental services; 1905(a)(10) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Adult Dental Services.

Pregnant individuals receive all medically necessary dental services, including the following preventative and restorative services:
* Preventive dental services:
- Oral exam every 12 months
- Cleaning every six months
- Fluoride treatment every 12 months
- Dental X-rays every 12 months (Full mouth or Panoramic every 36 months)

* Restorative Dental Services:
- Medically necessary exams
- Fillings are covered once in a 24-month period per tooth/surface
- Simple and surgical extractions
- Endodontic services include therapeutic pulpotomy and pulpa debridement
- Periodontic services include scaling and root planing, full mouth debridement
- Periodontal maintenance is covered up to 2 visits every 12 months

* Dentures:
-Dentures are covered once every 5 years
Limitations may be exceeded if medically necessary.

Non-pregnant adults who are past the month of their twenty-first (21st) birthday:
* The Department will cover emergency and palliative dental care required due to accidental injury.

Exclusions - The following non-medically necessary cosmetic services are excluded from payment under the Base Benchmark Benefit Package covered under the State Plan:
* Drugs supplied to dental patients for self-administration other than those allowed by applicable Department rules.
* Non-medically necessary cosmetic services are excluded from payment.

The Department may require prior approval for specific elective dental procedures for pregnant individuals.

Other 1937 Benefit Provided:
Outpatient Rehabilitation: OT, PT, SLP Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Retroactive Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Services are for the purpose of restoring certain functional losses due to disease, illness, or injury.

Other:
Program Description: Physical therapy and related services; 1905(a)(11) of the Act.

Services in excess of the Base Benchmark: Rehabilitation Services.

The Department covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services in excess of the Base Benchmark aggregate 20 visit limit. Claims exceeding current Medicare dollar caps are subject to targeted review for medical necessity.

Remove

Other 1937 Benefit Provided:
Outpatient Habilitation: OT, PT, SLP Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Retroactive Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Services for developing skills and functional abilities necessary for daily living and skills related to communication of persons who have never acquired them.

Other:
Program Description: Physical therapy and related services; 1905(a)(11) of the Act.

Services in excess of the Base Benchmark: Habilitation Services.

The Department covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services in excess of the Base Benchmark aggregate 20 visit limit. Claims exceeding current Medicare dollar caps are subject to targeted review for medical necessity.

Remove

Other 1937 Benefit Provided:
Bariatric Surgery

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

None

Other:

Program Description: Physician Services; 1905(a)(5)(B) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Bariatric Surgery.

Other 1937 Benefit Provided:

Prescription Drugs

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Program Description: Prescription Drugs: 1905(a)(12) of the Act.

Prescription Drugs: In excess of Base Benchmark.

The Department will cover either generic or brand if medically necessary.

The Department provides coverage for the following Medicare-excluded drugs or classes of drugs to all recipients of Medical Assistance under this State plan, including full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.
• Prescription drugs, including:
- Prescription cough and cold agents;
- Legend therapeutic vitamins, which include injectable vitamin B-12, vitamin K and analogues, and legend folic acid;
- Oral legend drugs containing folic acid in combination with vitamin B-12 and/or iron salts, without additional ingredients; and
- Legend vitamin D and analogues.
• Non-legend products, which include:
- Permethrin
- Federal legend medications that change to non-legend status, as well as their therapeutic equivalents. The Director determines that non-legend drug products are covered based on appropriate criteria, including safety, effectiveness, clinical outcomes, and the recommendation of the P&T Committee.
- Other non-legend drug products approved for coverage by the Director of the Department of Health and Welfare based on the determination of the Pharmacy and Therapeutics Committee that the non-legend product is therapeutically interchangeable with legend drugs in the same pharmacological class based on evidence comparison of efficacy, effectiveness, and safety and determined by the Department to be a cost-effective alternative. Information regarding the P&T Committee and covered drug products is posted at http://healthandwelfare.idaho.gov/Medical/PrescriptionDrugs/tabid/119/Default.aspx

Excluded drug products include:
- Legend drugs for which Federal Financial Participation is not available

- Ovulation stimulants and fertility-enhancing drugs
- Prescription vitamins, except injectable vitamin B-12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating individuals, and legend folic acid.

Other 1937 Benefit Provided: Preventive Health Assistance

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: Individualized benefits for individuals who are obese to address target health behaviors.

Other:

Program Description: This benefit is one of many preventive benefits that are included in this ABP. This benefit is covered in addition to the prevention and wellness benefits found in EHB 9 and is being approved as Secretary-Approved Coverage.

Other services covered by the Department, but not covered by the Base Benchmark: Preventive Health Assistance.

The Basic Alternative Benefit Plan includes certain Preventive Health Assistance (PHA) benefits for individuals in the target group, provided in accordance with applicable Department rules.

Basic PHA benefits are individualized benefits to address target health behaviors. Authorizations will be managed by the State Medicaid agency. PHA benefits made available under the Basic Alternative Benefit Plan will target individuals who are obese.

PHA benefits will be available when individuals complete specified activities in preparation for addressing the target health condition. These activities include discussing the condition with their primary care provider, participating in an applicable support group, and completing basic educational materials related to the condition.

PHA benefits may be used to purchase goods and services related to weight reduction/management rules. These goods and services may include weight-loss programs, dietary supplements, and other health-related benefits.

Other 1937 Benefit Provided: Home Health Care Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: 100 visits per year

Duration Limit: None

Scope Limit:

None

Other:

Program Description: Home Health Care Services; 1905(a)(7) of the Act.

Services covered in excess of the Base Benchmark: The Base Benchmark covers up to 20 visits per year combined for outpatient PT/OT/SLP services.

The Department will cover up to 100 visits without PA for any combination of Home Health Aide, Physical Therapy, Occupational Therapy, or Speech-Language Pathology services. More can be authorized when medically necessary. This benefit does not include Skilled Nursing services.

Other 1937 Benefit Provided:

Durable Medical Equipment

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Program Description: Home health care services; 1905(a)(7) of the Act.

Services in excess of the Base Benchmark: DME.
- The Department covers some items not covered by the Base Benchmark.
- The Department will replace DME more frequently than five (5) years when determined to be medically necessary.

Other 1937 Benefit Provided:

Podiatrist Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services to diagnose and treat medical conditions affecting the foot, ankle and related structures.

Routine foot care is not covered.

Other:

Program Description: Medical Care furnished by licensed practitioners; 1905(a)(6) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Podiatrist Services.

Other 1937 Benefit Provided:
Individual and Family Medical Social Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
Two (2) visits

Duration Limit:
Pregnancy and six (6) weeks postpartum

Scope Limit:
None

Other:
Program Description: Medical Care; 1905(a)(6) of the Act – Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

Other services covered by the Department, but not covered by the Base Benchmark: Services directed at helping a patient to overcome social or behavioral problems that may adversely affect the outcome.

Payment is available for two (2) visits during the covered period to a licensed social worker qualified to provide individual counseling according to the provisions of the Idaho Code and the regulations of the Idaho Board of Social Work Examiners. Additional services may be prior authorized.

Other 1937 Benefit Provided:
Targeted Case Management Services: IBHP

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Program Description: Targeted Case Management Services; 1905(a)(19) of the Act.

- Other services covered by the Department, but not covered by the Base Benchmark: Targeted Case Management in the Idaho Behavioral Health Plan.

- Except in cases where the participant has received in excess of 240 service units in a calendar year, services are not prior authorized, and there is no limitation in amount, duration, or scope.

- The target group consists of members of the Idaho Behavioral Health Plan who are:
1. Adults 18 and older with serious and persistent mental illness or other behavioral health diagnosis; or

2. Children up to age 21 with serious emotional disturbance or other behavioral health diagnosis; and
3. Who demonstrate medical necessity for case management services and require and choose assistance to access services and supports necessary to maintain independence in the community.

For case management services provided to individuals in medical institutions: [Olmstead letter #3]

~ Target group is comprised of individuals transitioning to a community setting, and case management services will be made available for up to the last 60 consecutive days of the covered stay in the medical institution.

~ Areas of State in which services will be provided: Entire State

~ Comparability of services: Services are not comparable in amount, duration and scope (§1915(g)(1)).

~ Definition of services: [42 CFR 440.169]
Behavioral Health Targeted Case Management services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational, and other services. Targeted Case Management includes the following assistance:

• Initial assessment and annual reassessment of an individual to determine the need for any medical, educational, social or other services. More frequent reassessments may be done more frequently if medically necessary. These assessment activities include:
- Taking client history;
- Identifying the individual's needs and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
• Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision-maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.
• Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with:
- Medical, social, educational providers; or
- Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
• Monitoring and follow-up activities:
- Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure that the following conditions are met:
~ Services are being furnished in accordance with the individual's care plan;
~ Services in the care plan are adequate; and
~ If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements with providers.

~ Targeted case management may include:
Contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

~ Qualifications of Providers:
The Targeted Case Management benefit is provided by a PAHP-contracted and qualified provider as established by the contract, and set forth below for minimum provider qualifications. Service providers are subject to the limitations of practice imposed by State Law, Federal Regulations, The State of Idaho Occupational Licensing requirements, the provider's professional area of competency and as according to applicable Department Rules, approval by the Department and its Pre-paid Ambulatory Health Plan (PAHP) Contractor as established in the contract.
• Minimum Provider Qualifications for Targeted Case Management providers are PAHP contractors: Licensed Physician, Licensed Psychiatrist, Licensed Practitioner of the Healing Arts (Advanced Practice Registered Nurse, Nurse Practitioner, Physician Assistant), Licensed Prof. Nurse, RN, Cert. Psychiatric Nurse, RN, Licensed Prof. Nurse, RN, Licensed Social Worker, Licensed Counselor, Licensed Registered Occupational Therapist, Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses), Licensed Marriage and Family Therapist, holding at least a Bachelor's degree and a Certification or Licensing in their fields and meeting requirements of Idaho Department of Health and Welfare or its Contractor.

~ Waiver of Freedom of Choice of Providers
As permitted and authorized under section 1915(b)(4) of the Social Security Act, choice of targeted case management providers is waived. Behavioral Health targeted case management will be provided by the prepaid ambulatory health plan for the Idaho Behavioral Health Plan.
• Eligible recipients will have free choice of providers of other medical care under the state plan.

~ Freedom of Choice Exception (1915(g)(1) and 42 CFR 441.18(b)):
Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

~ Access to Services. The State assures that:
• Case management services will be provided in a manner consistent with the best interests of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]
• Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]
• Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

~Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

~Case Records (42 CFR 441.18(a)(7)):
The State assures that providers maintain case records that document the following for all individuals receiving case management [42 CFR 441.18(a)(7)]:
• The dates of the case management services.
• The name of the provider agency and the person providing the case management services.
• The nature, content, and units of the case management services received, and whether goals specified in the care plan have been achieved.
• Whether the individual has declined services in the care plan.
• The need for, and occurrences of, coordination with other case managers.
• A timeline for obtaining needed services.
• A timeline for reevaluation of the plan.

~Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) § 4302).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (42 CFR 441.18(c))

FFP is only available for case management services or target case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program, except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Remove

Other 1937 Benefit Provided: Dentures

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: One (1) set every five (5) years

Duration Limit: None

Scope Limit: Dentures for the purpose of restoring oral form and function due to loss of permanent teeth that would result in significant occlusal dysfunction.

Other: Dentures are covered only for children through the month of their twenty-first (21st) birthday, and pregnant individuals when medically necessary.

Remove

Other 1937 Benefit Provided: Audiology

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

Certain services require prior authorization.

Audiologist services are covered for individuals with hearing disorders when provided by an audiologist who is licensed by the Speech and Hearing Services Board of the Idaho Board of Occupational Licenses.
~ Participants age 21 and older are eligible to receive diagnostic audiology services necessary to obtain a differential diagnosis.
~ Participants under the age of 21 are eligible to receive necessary audiometric services and supplies.
~ The Department will prior authorize audiometric examination/testing if needed more frequently than once per year.

Other 1937 Benefit Provided:

Behavioral Consultation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

36 hours per student per year

Duration Limit:

None

Scope Limit:

This service is provided to students in an educational setting pursuant to a signed and dated recommendation or referral by a physician or allowed non-physician practitioner.

Other:

Program Description: Other diagnostic, screening, preventive, and rehabilitative services - 1905(a)(13)(C) of the Act.

- Behavioral consultation supports a multi-disciplinary approach to rehabilitative and treatment by consulting with the IEP team during the assessment process for a specific child, performing advanced assessment of the child, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members for a child's needs.

Behavioral consultation provides expertise for children with complex needs who are not demonstrating outcomes with behavioral interventions alone. The consultant works with the IEP team and other professionals to develop a positive behavior support plan and provide oversight in carrying out that plan to reduce disability and increase function.

- Qualifications for Behavioral Consultation providers are:
~ Behavioral consultation must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or in a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program), and who meets one (1) of the following:
~ An individual with an Exceptional Child Certificate as defined by State law.
~ An individual with an Early Childhood/Early Childhood Special Education Blended Certificate as defined by State law.
~ A Special Education Consulting Teacher as defined by State law.
~ An individual with a Pupil Personnel Certificate as defined by State law, excluding a registered nurse or audiologist.
~ An occupational therapist who is qualified and registered to practice in Idaho.

~ Therapeutic consultation professional who meets the requirements defined by the Department.

- Services provided in the schools must be the same in amount, duration and scope as the services provided in the community.
- Individuals delivering services in the schools must adhere to the same provider qualifications as required for individuals delivering services in the community.
- Participants are able to choose to receive Medicaid services from the pool of qualified Medicaid providers, which includes school-based and community providers.
- Participants through the month of their twenty-first (21st) birthday, pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Other 1937 Benefit Provided:

Behavioral Intervention

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

This service is provided to students in an educational setting pursuant to a signed and dated recommendation or referral by a physician or allowed non-physician practitioner.

Other:

Program Description: Behavioral Intervention: 1905(a)(13)(C) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Behavioral Intervention.

- Behavioral intervention is based on a treatment plan developed by the family and a multidisciplinary team that also writes the IEP.

- Behavioral Intervention is used to promote the student's ability to participate in educational services through a consistent, assertive, and continuous intervention process. It includes the development of replacement behaviors with the purpose to prevent or treat behavioral conditions of students who exhibit maladaptive behaviors.

- The behavioral intervention treatment plan is developed and implemented by the multi-disciplinary team. The parents/guardian are included in the development of the plan.

- Qualifications for a Behavioral Intervention Professional are as follows:
~ An individual with an Exceptional Child Certificate as defined by State law; or
~ An individual with an Early Childhood/Early Childhood Special Education Blended Certificate as defined by State law; or
~ A Special Education Consulting Teacher as defined by State law; or
~ Habilitative intervention professional who meets the requirements defined by the Department; or
~ Individuals employed by a school as certified Intensive Behavioral Intervention (IBI) professionals prior to July 1, 2013, who are qualified to provide behavioral intervention; and
~ The individual must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities.

- Qualifications for a Behavioral Intervention Paraprofessional are as follows:
~ Must be at least eighteen (18) years of age;
~ Must demonstrate the knowledge, have the skills needed to support the program to which they are assigned, and meet the requirements under the "Standards for Paraprofessionals Supporting Students with Special Needs," available online at the State Department of Education website; and
~ Must meet the paraprofessional requirements under the Elementary and Secondary Education Act of 1965, as amended, Title 1, Part A, Section 1119.
~ A paraprofessional delivering behavioral intervention services must be under the supervision of a behavioral intervention professional or behavioral consultation provider.

Other 1937 Benefit Provided:
Skilled Nursing Facility

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
30 days per year

Duration Limit:
None

Scope Limit:
Skilled Nursing Facility services for rehabilitation.

Other:
Program Description: Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; § 1905(a)(4)(A) of the Act.

Services in excess of the Base Benchmark: Skilled Nursing Facility services.

* The Department will prior authorize services exceeding the 30-day limit in the Base Benchmark when such services are determined to be medically necessary.

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- B

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

○ Through an Alternative Benefit Plan.

◉ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

◉ State/territory provides additional EPSDT benefits through fee-for-service.

○ State/territory contracts with a provider for additional EPSDT services.

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Behavioral health and dental services are provided through PAHP contracts that require the contractor to provide EPSDT services. Participants maintain their right to appeal through through the Department. All EPSDT medical/surgical and developmental disability services are provided through fee-for-service. Department policy is that any decisions for the payment or prior authorization of services for children through the month of their twenty-first (21st) birthday be reviewed as an EPSDT request.

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Alternative Benefit Plan

Other Benefit Assurances

- ☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- ☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- ☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- B

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☐ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☒ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

Idaho's PCCM program is operated in accordance with 42 CFR 438, and is an ongoing program with no new implementation outreach activities are anticipated at this time. However, at the time of enrollment, all new participants are informed about PCCM, and given the opportunity to choose their primary care provider. Information for participants about the PCCM program is found in the Idaho Health Plan Coverage booklet, which is available online. Department representatives visit physicians and non-physician practitioners to keep them informed about Idaho's PCCM program.

PCCM: Primary Care Case Management

The PCCM delivery system is the same as an already approved PCCM program. No

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

PCCM service delivery is provided on less than a statewide basis. No

PCCM Payments

Specify how payment for services is handled:

◉ Per member/per month case management fee paid to PCCM provider.

○ Other:

Additional Information: PCCM (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Except for the Dental and the Behavioral Health services, the Basic Alternative Benefit Plan is furnished on a fee-for-service basis for all participants consistent with the requirements of section 1902(a) and implementing regulations relating to payment and participant free choice of provider.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

V.20130718

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- B

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- [x] Managed care.
  - [ ] Managed Care Organizations (MCO).
  - [ ] Prepaid Inpatient Health Plans (PIHP).
  - [x] Prepaid Ambulatory Health Plans (PAHP).
  - [ ] Primary Care Case Management (PCCM).
- [ ] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The Contractor is pursuing outreach activities with the goal of improving access to preventive services for children and pregnant individuals and to address the problems of early childhood dental caries by ensuring that children ages 0 - 3 have a dental home. The contract requires that the Contractor conduct outreach activities and programs to educate participants about their dental benefits and the importance of preventive dental care. Outreach efforts are to focus on the best and most cost-effective use of resources. Outreach may be accomplished through a variety of methods including, but not limited to, mailings, newsletters, website information, and contractor affiliations with other community, healthcare, and government health outreach programs.

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ◉ Section 1915(b) managed care waiver.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Alternative Benefit Plan

Identify the date the managed care program was approved by CMS: Jun 29, 2017

Describe program below:

Through a program known as Idaho Smiles, the Department covers dental services for eligible participants, administered through a PAHP contract. Idaho Medicaid was approved for its 1915(b) waiver for the Idaho Smiles dental pre-paid ambulatory health plan in 2015. CMS approved a renewal of the Idaho Smiles Section 1915(b) managed care waiver on June 29, 2017, with an effective period of July 1, 2017 through June 30, 2022.

The Department contracted with a single, statewide managed care entity, Managed Care North America, dba MCNA Dental, which meets the requirements of a PAHP (as defined in 42 CFR § 438.8(b)). MCNA manages a network of providers across the state in order to administer behavioral health services to eligible Medicaid participants.

Medicaid provides for an IDHW Contract Manager to to assure compliance with federal financing requirements and to lead ongoing contract administration and contract performance monitoring with overall responsibility for the management of all aspects of the contract.

Idaho Medicaid's goals for the dental program PAHP is to provide for participants' dental needs while ensuring quality service, maintaining consistency of care, maximizing use of technology, providing timely and dependable service delivery, preventing fraud and containing costs.

Idaho determines eligibility and conducts annual redetermination for every participant for ongoing Medicaid services. All participants are enrolled into the Idaho Smiles dental plan when Medicaid eligibility is established. Idaho is responsible for ongoing eligibility determinations, enrollment and dis-enrollment. The contractor provides covered services which includes equal access to services, ensures quality services, maintains consistency, contains costs, maximizes use of technology, provides timely and dependable service delivery and fraud prevention. As of June 30, 2016, the statewide provider network for rural areas consists of 195 providers in 55 locations serving 107,246 participants in urban areas, the network consists of 363 providers in 38 locations serving 179,017 participants. Overall, approximately half of all licensed dentists in the state were enrolled in 2016.

Additional Information: PAHP (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

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Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☐ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☒ Prepaid Ambulatory Health Plans (PAHP).
- ☐ Primary Care Case Management (PCCM).

☐ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

Stakeholder meetings were held in 2012, and continuous feedback solicited through the Department's website. In 2013, Idaho sent notification regarding implementation of the managed care contract was sent to all participants and providers. The contract requires that the Contractor shall have a Communication Plan that includes a plan to communicate with participants, providers and stakeholders, including participant service and provider service call centers and participant and provider handbooks. Participant handbooks were mailed in August of 2013, prior to implementation.

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ◉ Section 1915(b) managed care waiver.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: Mar 30, 2017

Alternative Benefit Plan

Describe program below:

The Department covers community-based outpatient behavioral health services through a PAHP contract. The implementation date of the managed care delivery system was September 1, 2013. CMS approved a renewal of the IBHP Section 1915(b) managed care waiver on March 30, 2017, with an effective date of April 1, 2017 and an expiration date of March 31, 2022.

The Department contracted with a single, statewide managed care entity, United Behavioral Health, dba Optum Idaho, which meets the requirements of a PAHP (as defined in 42 CFR § 438.8(b)). Optum manages a network of providers across the state in order to administer behavioral health services to eligible Medicaid participants.

The Department has designated the Division of Medicaid to oversee the Idaho Behavioral Health Plan to assure compliance with federal financing requirements. Medicaid provides for an IDHW Contract Manager to lead ongoing contract administration and contract performance monitoring with overall responsibility for the management of all aspects of the contract.

Through the implementation of a managed care system under a 1915(b) waiver, Idaho seeks to achieve the following goals:
Short-term Goals:
* Enrollment of sufficient number of competent professionals to deliver core services; Successful claims processing; Improved identification of Members who meet program qualifications for behavioral health treatment; and Successful transition process for both providers of services (agencies and individual practitioners) and participants.

Intermediate Goals:
* Effective communications between the IDHW, Contractor and all other stakeholders; Increases in number of participants who receive behavioral health care treatment that accurately matches their behavioral health care needs; Implementation of utilization management and quality assurance processes that result in improved operations/services and improved payment approaches; and Improved coordination with all other treatment providers and programs that participants are involved with; specifically, the Healthy Connections program.

Long-term Goals:
* Positive outcomes for participants that result in participants' recovery and/or resiliency; Decreased inappropriate use of higher cost services (hospital, emergency departments, crisis); Administrative efficiencies realized that include greater reliance on technology, cost-effective management of the network and of services, and decrease in waste and fraud; and Greater satisfaction with treatment and support services among participants and greater satisfaction for agencies and practitioners in the administration of the services.

Additional Information: PAHP (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- B

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. **Yes**

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid-covered services provided to individuals enrolled in the Basic Alternative Benefit Plan (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the Basic Alternative Benefit Plan (subject to any nominal Medicaid co-payment) for eligible individuals in employer-based cost-effective group health plans.

When coverage for Medicaid-eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan.

Cost effectiveness is determined by comparing the total amount paid by the primary insurance company to the premiums and deductible. If the primary insurance has paid more than the premiums and deductible, the case is cost effective. If the primary insurance has paid less than the premiums and deductible, the case is NOT cost effective.

The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums. **No**

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- B

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- B

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

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